OFFICIAL

INDEPENDENT CLINIC - NORPLANT SYSTEM REIMBURSEMENT Attachment 4.19B

1. Reimbursement for the Norplant System provided in an independent clinic will be a global fee-for-service which includes a component for the package price and a component for the surgical services. The fee-for-service will be periodically increased to reflect the increase in the price by the manufacturer when provided by physician in his or her office or by an independent clinic (except for an ASC).

2. Reimbursement to a Federally Qualified health center for the insertion, reinsertion, and/or removal of the NPS is at the encounter rate.

TN 93-33 Approval Date NOV 24 1993

Supersedes TN New Effective Date JUL 1 - 1993

OFFICIAL

Independent Clinic - Depo-Provera Attachment 4.19B

Reimbursement for Depo-Provera when used for contraceptive purposes shall be done in the following manner:

Reimbursement for this Level III HCPCS code is based on the Average Wholesale Price (AWP) of a single dose of Depo-Provera or the clinic's acquisition cost, whichever is less, when the drug is administered in an independent clinic. The Medicaid maximum fee allowance for this drug will be adjusted periodically by the program to accommodate changes in the market cost.

TN 93-34 Approval Date DEC 10 1993

Supersedes TN New Effective Date JUL 1 - 1993

PHARMACEUTICAL SERVICES

Payment for drugs shall be as follows:

1.16 Basis of payment

(a) Payment for legend drugs (those drugs whose labels include the legend "Caution: Federal Law Prohibits Dispensing Without a Prescription"), contraceptive diaphragms and reimbursable devices will be based upon the maximum allowable cost. This means the lower of the upper payment limit price list (MAC price) as published by the Federal government or the average wholesale price (AWP).

1. Maximum allowable cost is defined as:

   i. The MAC price for listed multi-source drugs published periodically by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services; or

   ii. For legend drugs not included in (a)1i above, the Estimated Acquisition Cost (EAC), which is defined as the average wholesale price (AWP) listed for the package size (billed to the New Jersey Medicaid program), in current national price compendia or other appropriate sources (such as the First Data Bank (FDB) reference drug file contractor), and their supplements, minus a 10 percent volume discount.

2. If the published MAC price as defined in (a)1i above is higher than the maximum allowable cost which would be paid as defined in (a)1ii above, then (a)1ii above shall apply.

(b) The calculated discount shall be automatically deducted, regardless of prescription cost, by the fiscal agent, from the cost of each covered drug or device during claim processing by the New Jersey Medicaid Management Information System (NJMMIS).

TN 96-29 Approval Date OCT 21 1996
Supersedes TN 87-208 Effective Date JUL 15 1996

OFFICIAL

1.17 Presoription dispensing fee

(a) The dispensing fee for legend drugs, dispensed by providers having retail permits to beneficiaries other than those in nursing facilities, shall be established by State regulation. Additional dispensing fees (add-ons) per prescription shall be given to pharmacy providers who provide the following:

1. Twenty-Four Hour Emergency Service: The provider shall have a 24-hour per day, 365 days per year prescription service available and shall have provided Medicaid beneficiaries opportunities to utilize this service.

2. Patient Consultation. In addition to routinely monitoring beneficiary profiles for drug interactions, contraindications, allergies, etc., the provider shall, where appropriate, discuss the course of drug therapy with the beneficiary. This discussion must include emphasis on compliance with the prescriber's orders; proper drug utilization; cautions about possible side affects; foods to avoid; proper drug storage conditions; and any other information that will prove beneficial to the beneficiary while on drug therapy.

3. Impact Area Location. The provider shall have a combined Medicaid and PAAD prescription volume equal to or greater than 50 percent of the provider's total prescription volume.

   i. The nursing facility prescription volume shall be included for the determination of total prescription volume in determining entitlement to the impact allowance.

(b) Price information is supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The calculated price shall not exceed the lower of the average wholesale price (AWP) or the Federal Financial Participation Upper Limit (FFPUL) as supplied by the reference drug file contractor.

(c) In order to receive any or all of the above increments, the provider shall certify annually to the Division on Form FD-70, that the services(s) as defined in (a) above, are being provided and/or that the provider is entitled to the impact increment as defined in (a) above.

TN 96-29 Approval Date OCT 21 1996

Supersedes TN 96-11 Effective Date JUL 1 1996

1. Each claimed increment is subject to audit and retroactive recovery with appropriate penalties, if warranted, if the New Jersey Medicaid program determines that the provider was not entitled to reimbursement for them.

1.18 Capitation of Dispensing Fee for Legend Drugs to Long-Term Care patients.

(a) The New Jersey Medicaid program capitates the dispensing fee for legend drugs for patients in Medicaid approved long-term care facilities in accordance with the total number of Medicaid patient days in the facility(ies) serviced by the pharmacy. The Capitation fee is established by regulation.

1. Pharmacies with retail permits dispensing medication in a dispensing system in which a 24-hour supply of unit dose oral medication, both solid (i.e. tablets, capsules) and liquid formulations, is delivered for each patient daily, will be reimbursed the cost of all reimbursable legend medication plus a fee per patient day.

i. Exception: Certain liquid medications that are supplied in concentrate form only and are administered by drop dosage cannot be supplied in a 24-hour dose.

2. Pharmacies with a retail permit dispensing medications in a dispensing system in which up to a one month supply or oral unit dose solid medication is delivered for each patient (i.e., unit dose solids modified unit dose system) will be reimbursed the cost of all reimbursable legend medication plus a fee per patient day.

3. Pharmacies with a retail permit dispensing medication in a dispensing system in which a maximum one month supply of medication is delivered for each patient monthly will be reimbursed the cost of all reimbursable medication plus a fee per patient day.

4. Pharmacies which provide ancillary computerized services, such as, but not limited to, continuously updated computerized patient profiles, clinical records (med sheets and physicians' orders on at least a monthly basis), etc., will receive an added increment per patient day.

5. Pharmacies with institutional permits will be reimbursed as above, except that the daily per patient capitation fee will be 75 percent of the fee for pharmacies with retail permits.

TN 96-29 Approval Date OCT 2 1 1996
96-11 7-15-96

MAXIMUM CHARGES - LONG TERM CARE

(a) The maximum charge to the New Jersey Medicaid program for a legend drug, including the charge for the cost of medication and the capitation fee, may not exceed the lowest of the following:

1. The charges made to other medical facilities or agencies through contracts or other agreements; or

2. "MAC/EAC" plus capitation fee, as outlined above, or

3. Usual and customary and/or posted or advertised charges; or

4. Other third-party prescription plan payments.

(b) When such contract or other agreements with a medical facility or agency exist, (a) above will apply to claims submitted on behalf of Medicaid recipients in said facility or receiving services by said agency.

(c) Pharmacies using more than one drug distribution system at a long-term care facility, will receive reimbursement for all legend drugs based upon the lowest priced distribution system supplied to that long-term care facility.

1.19 LEGEND DRUGS: TOTAL CHARGE

(a) The maximum charge to the New Jersey Medicaid program for a legend drug, including the charge for the cost of medication and the dispensing fee, may not exceed the lowest of the following:

1. "MAC/EAC" plus dispensing fee, as outlined in section 1.16; or

2. Usual and customary and/or posted or advertised charges; or

3. Other third-party prescription plan payments.

1.20 COMPOUNDED PRESCRIPTIONS

(a) Any prescriptions containing two or more ingredients in usually accepted therapeutic dosage and combined by a pharmacist at the time of dispensing is a compounded prescription and will be charged as follows:

TN 96-29 Approval Date OCT 2 1 1996
Effective Date JUL 1 5 1996

1. Total ingredient cost is defined in Section 1.16(a)1. The provider may charge up to $0.25 for any ingredient whose "cost" is less than $0.25; plus

2. The dispensing fee as allowed in Section 1.17.

3. The maximum charge for a compounded prescription will not exceed the limits set forth in Section 1.19.

1.21 NON-LEGEND DRUGS

(a) The only non-legend drug products that are eligible for reimbursement under the New Jersey Medicaid program are:

1. Insulin, diabetic testing materials, insulin syringes and needles;

2. Antacids;

3. Family planning materials and supplies;

4. Protein replacement supplements and other special items.

(b) The maximum allowance for non-legend drug products under the New Jersey Medicaid program, is determined by the lower of:

1. The Estimated Acquisition Cost (EAC), which is defined as the average wholesale price (AWP) listed for the package size (billed to the New Jersey Medicaid program), in current national price compendia or other appropriate sources (such as the First Data Bank (FDB) reference drug file contractor), and their supplements, minus a 10 percent volume discount; plus dispensing fee; or

2. The provider's usual and customary charge.

TN 96-29 Approval Date OCT 21 1996

Supersedes TN 87-20B Effective Date JUL 15 1996

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Services

PROSTHETIC AND ORTHOTIC APPLIANCES

The reimbursement policy for the purchase or repair of any appliance or orthopedic footwear is in accordance with the lower of the Title XIX maximum fee allowance or the provider's usual and customary charge.

An additional labor charge is available only for repair-related activities after expiration of the warranty or as a result of a change of the prescription. Labor is not reimbursable for a new item or appliance.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Services

VISION CARE SERVICES

Reimbursement for covered services shall be on the basis of the customary charge not to exceed an allowance determined reasonable by the Commissioner of the Department of Human Services, and further limited by federal policy, where applicable, relative to practitioners and other providers.

In no event shall the charge to the Title XIX programs exceed the charge by the provider for identical services and/or items to other governmental agencies, private non-profit agencies, trade unions, or other individuals in the community.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Services

HEARING AIDS

(a) Reimbursement for a new hearing aid is based on the lesser of the following:

The provider's usual and customary charges; or the wholesale cost of the instrument and earmold, plus batteries, plus insurance, shipping, and handling costs included as a component of the manufacturer's cost, plus dispensing fee.

(b) Reimbursement for a returned hearing aid is based on the lesser of the following:

The provider's usual and customary charge; or the wholesale cost of the earmold; plus batteries, cord and garment bag, plus manufacturer's restocking fee, if any, plus a service fee.

(c) Replacement of an aid within one year from date of original dispensing, if not covered by the manufacturer's warranty, is based on the lesser of the following:

The provider's usual and customary charge; or the wholesale cost of the instrument and earmold, plus the insurance, shipping, and handling costs included as a component of the manufacturer's cost, plus a dispensing fee.

(d) Reimbursement for repair of a hearing aid, if not covered by the manufacturer's warranty, is based on the lesser of the following:

The provider's usual and customary charge; or the manufacturer's cost of repair, plus a 50 percent service fee.

(e) Reimbursement for earmolds, if not covered by the manufacturer's warranty, is based on the lesser of the following:

The provider's usual and customary charge; or the wholesale cost, as per laboratory invoice or laboratory price list, plus a servicing fee.

(f) Reimbursement for batteries and supplies is based on the lesser of the provider's usual and customary charge or the manufacturer's list price less 20 percent.

(g) Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).